Supreme Court, U.S.
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85-431

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

HUMANA INC. *et al.*,
Petitioners,

v.

MARGARET M. HECKLER, Secretary,
Department of Health and Human Services,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

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QUESTION PRESENTED

Whether Congress, in providing for reimbursement to hospitals for their "direct and indirect" costs of furnishing hospital services to Medicare beneficiaries, *see* 42 U.S.C. § 1395x(v)(1)(A), intended that investor-owned hospitals be reimbursed for their actual costs of attracting and maintaining equity capital used in the provision of patient care.

PARTIES TO THE PROCEEDING

In addition to petitioner Humana Inc., the other parties appearing as appellants in the proceeding below were: Humana of Kentucky, Inc., Humana of Alabama, Inc., Humana Medical Corporation, Humana of Tennessee, Inc., Humana of Texas, Inc., Beaumont Hospital, Inc., Humana of Louisiana, Inc., Winnfield Convalescent Home, Inc., Many Clinic & Hospital, Inc., Brentwood Hospital, Inc., Jefferson Hospital, Inc., Humana of South Carolina, Inc., Humana of Virginia., Inc., Humana of West Virginia, Inc., Humana of North Carolina, Inc., Humana of Florida, Inc., Humana of Illinois, Inc., Humana of Mississippi, Inc., Humana of Aurora, Inc., Humana of New Mexico, Inc., Humana of Kansas, Inc., and Humana of Utah, Inc. All of these additional corporations are wholly-owned subsidiaries of petitioner Humana Inc.*

Appellee below and Respondent here is Margaret M. Heckler, in her official capacity as Secretary of the United States Department of Health and Human Services.

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* Humana Inc. is a publicly-traded company with stock traded on the New York Stock Exchange. In addition to the other petitioners, Humana Inc. does business through a number of other wholly-owned subsidiaries.

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Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

Humana Inc. *et al.* petition for a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the District of Columbia in this case.

OPINION BELOW

The *per curiam* opinion of the United States Court of Appeals for the District of Columbia (App., 1a-22a) is reported as *Humana Inc. v. Heckler,* 758 F.2d 696 (D.C. Cir. 1985). On April 26, 1985, the Court, *sua sponte,* issued an amendment to the decision (App., 23a-24a). The August 19, 1982 memorandum opinion of the district court is unreported and is reproduced in the Appendix. (App., 25a-37a).

JURISDICTION

The judgment of the Court of Appeals was issued on April 2, 1985 *as amended,* April 26, 1985. *See* Appendix K. A timely petition for rehearing was denied on June 18, 1985. *See* Appendix L. This petition for certiorari is being filed within ninety (90) days of that date. This Court's jurisdiction is being invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

1. Title XVIII of the Social Security Act requires the Federal Hospital Insurance Trust Fund to reimburse hospitals for the "reasonable costs" of services provided to Medicare patients. 42 U.S.C. § 1395(b)(1); 42 U.S.C. § 1395g(a). The Act defines "reasonable costs" as follows (42 U.S.C. § 1395x(v)(1)(A):

> The reasonable cost of any services shall be the cost actually incurred * * * and shall be determined in accordance with regulations establishing the method of methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a

> provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

2. In 1966, Congress amended the Medicare Act to specify the method to be used to calculate the rate of return on equity capital to be paid to nursing homes (Public Law No. 89-713, 7, 80 Stat. 1111 (November 2, 1966), *codified at* 42 U.S.C. § 1395x(v)(1)(B):

> Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

3. The Secretary of Health and Human Services has promulgated regulations to govern the return on equity payable under Medicare both to hospitals and nursing homes (42 C.F.R. § 405.429(a)(1)-(2)):

> (1) A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers. The amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(2) For the purposes of this subpart, the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

* * *

STATEMENT OF THE CASE

Few sectors of the American economy have experienced the degree of government intervention in the marketplace that has been visited upon the acute care hospital industry since 1965 after passage of the Medicare Act. In the past two decades, nevertheless, this Court has not interpreted the substantive reimbursement provisions of the Act as they relate to hospitals. In the absence of guidance from this Court, the Secretary of Health and Human Services has implemented the Medicare Act on the assumption that she is writing on a clean slate, and therefore has unlimited discretion to define the rights of investor-owned companies that operate hospitals providing services to Medicare patients. In implementing the Program, however, the Secretary has acted contrary to both longstanding precedent of this Court and congressional intent underlying the Act by refusing to compensate investor-owned hospitals for the actual costs associated with equity capital invested and used in furnishing medical care to Medicare patients.

During the past 100 years the Supreme Court consistently has enforced the basic principle that private enterprise is entitled to compensation for their capital costs, including both the return on equity that must be paid to shareholders for use of their investment capital and the attendant income tax liability incurred by the corporation in generating that return. The Court initially relied on the constitutional prohibition of a taking of private property for public use without just compensation to protect public utilities subject to state or federal ratemaking programs. Subsequently, the Court concluded that

statutes prescribing compensation levels to investor-owned companies other than public utilities were "coextensive" with the Constitution's "just compensation" standard, thus making it unnecessary to invoke the constitutional provision directly.

The merger of just compensation standards and statutory requirements is best reflected in the Court's decision in *Federal Power Commission v. Natural Gas Co.*, 315 U.S. 575 (1942). There the Court concluded that payment levels to natural gas producers, established by agency regulation pursuant to the statutory program, had to satisfy the constitutional principle of just compensation. 315 U.S. at 586. Thus, natural gas producers were entitled by statute to just compensation, including the costs of attracting and maintaining equity capital, even though their sales of natural gas under that statute were entirely voluntary and therefore the constitutional protection otherwise available to public utilities was not directly available to them.

Humana Inc. is an investor-owned corporation that, with its wholly-owned subsidiaries, furnishes hospital services to individuals eligible for assistance under the Medicare Act. Under the Act, Congress specified that hospitals are entitled to reimbursement for their "direct and indirect costs" actually incurred in furnishing hospital services to eligible beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). In this litigation, Humana seeks to vindicate its right as an investor-owned corporation to compensation for its actual costs of private equity capital which it has employed in furnishing patient care, consistent with congressional intent and with the protections afforded every other investor-owned company in every other industry under similar statutory control.

In the decision below, the United States Court of Appeals for the District of Columbia Circuit ignored historic precedent and rejected Humana's claim that the cost of capital was a cost of patient care. Indeed, the decision in itself is internally inconsistent on the fundamental issue which Humana must ask the Court to address. Citing the provisions of 42 U.S.C. § 1395x(v)(1)(A) which require reimbursement of the "direct and indirect costs" of patient care, the court of appeals

recognized that "Indirect costs include such items as return on equity capital . . . ." [1] Nevertheless, the *Humana* court concluded that a prior decision in its circuit "preclude[d] a finding that return on equity is payable under § 1395x(v)(1)(A) . . . ." [2] As a result of this decision, Humana was not reimbursed for its actual costs of furnishing patient care to Medicare patients, and it was denied the procedural protections established by the Medicare Act to govern disputes regarding reimbursement for "costs."

The reasoning offered by the court of appeals to justify its conclusion cannot withstand scrutiny under precedent of this Court. Further, the court of appeals ignored the legislative history of the Medicare Act that demonstrates Congress' unequivocal intention that the actual capital costs of investor-owned hospitals be treated as "costs" of patient care. Therefore, Humana respectfully petitions the Court for a writ of certiorari to the Court of Appeals for the District of Columbia Circuit to review the decision below.

A. Procedural History.

1. During its fiscal years ending 1973 through 1977, Humana furnished acute care hospital services to patients eligible for benefits under the Medicare Program. Consistent with the Medicare Act and their contracts with the Secretary, Humana's hospitals filed annual cost reports and successive claims for payment at the close of each fiscal year. *See* 42 U.S.C. § 1395h; § 1395oo. Upon receiving these reports the Secretary's "fiscal intermediary," an insurance company such as Blue Cross which contracts with the Secretary to administer the Program, audited Humana's cost reports and rendered an initial determination as to the amount of reimbursement to which it believed Humana was entitled.

2. In the cost reports filed with the intermediaries Humana included claims for reimbursement for three categories of costs

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[1] App., 3a.

[2] App., 14a, *citing American Medical International v. Secretary*, 466 F. Supp. at 613 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981).

it incurred by reason of its status as a proprietary, investor-owned organization. These "proprietary" costs include:

> (1) *Return On Equity.* To attract and maintain equity capital, Humana must earn a return on the equity capital of the company, which is either distributed to shareholders as a return on their investment or reinvested in the company.
>
> (2) *Income Taxes.* The federal and state income taxes levied on Humana's return on equity reduce the total earnings available to distribute to Humana's shareholders. Because shareholders make investment decisions on the basis of the after-tax earnings of the company—*i.e.*, the total amount available for distribution to shareholders—the after-tax return on equity earned by Humana must be competitive in the capital markets from which it obtains investment capital.
>
> (3) *Stock Maintenance Costs.* Humana directly incurs transactional costs to gain access to equity capital markets, from which it obtains private investment capital. These expenses include accounting and other costs related to Securities and Exchange Commission filings, stock transfer fees, and the costs of shareholder meetings and annual reports.[3]

Upon completing its audit of Humana's cost reports, the fiscal intermediaries denied in whole or in part Humana's claims for reimbursement of each of these costs.[4]

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[3] Humana sought reimbursement for Medicare's share of Humana's stock maintenance costs and federal and state income tax liability. In addition, Humana sought Medicare reimbursement for Humana's actual, after-tax cost of attracting and maintaining equity capital invested in the facility. While the Program reimburses investor-owned hospitals for a return on equity capital at a rate established by a regulatory formula, *see* 42 C.F.R. § 405.429, Humana contends that the rate prescribed by regulation is illegal because it yields an after-tax rate far below Humana's actual cost of capital. *See infra* at 16-17.

[4] Humana's claims for reimbursement of Medicare's share of its stock maintenance costs and federal and state income taxes were denied outright. Humana's claims for reimbursement of its actual costs of equity capital were denied to the extent they exceeded the amount permitted under 42 C.F.R. § 405.429. *See* Appendices D-J.

3. Pursuant to the Act, Humana appealed the intermediary's determination to the Provider Reimbursement Review Board, an adjudicative panel within the Department of Health and Human Services. *See* 42 U.S.C. § 1395oo. Although the Board granted Humana's claims for some of these costs,[5] the Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, reversed those decisions and denied all of Humana's claims. *See* 42 U.S.C. § 1395oo(f).

4. Exercising its right to judicial review of the agency decision, *see* 42 U.S.C. § 1395oo(f), Humana filed complaints in the United States District Court for the District of Columbia seeking review of each of the decisions of the Board (or the Administrator) denying Humana's claims for the five fiscal years.[6] In an unreported memorandum decision dated August 19, 1982, the district court entered summary judgment against Humana on all of the claims for reimbursement of proprietary costs. App., 25a-37a. On appeal, the United States Court of Appeals for the District of Columbia Circuit affirmed the district court decision. *Humana Inc. v. Heckler*, 758 F.2d 696 (D.C. Cir. 1985); App., 1a-24a.[7]

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[5] *See* 42 U.S.C. § 1395oo(f)(1). The Board upheld Humana's claims for stock maintenance costs for all fiscal years at issue and Humana's claims for income taxes in its fiscal years ending 1976 and 1977 to the extent those taxes are attributable to the return on equity paid to Humana. *See Humana Inc.*, PRRB Dec. No. 81-D12 (Feb. 5, 1981) (App., Appendix D).

[6] The fifth lawsuit, No. 82-1989, involves the separately-filed claims of one of the Humana subsidiaries, Humana of South Carolina, Inc. In that action the individual subsidiary challenged the legality of 42 C.F.R. § 405.429 without first presenting its claims to the Provider Reimbursement Review Board. After it was determined that the district court did not have jurisdiction to hear those claims until after they had been considered by the Board, *see Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978), the case was consolidated with the others then pending in the district court. *See* App., 4a n.7.

[7] Throughout the administrative and judicial process, twelve of Humana's hospitals also had asserted distinct claims for reimbursement of other capital costs denominated by the court below as "stock acquisition costs." The Court of Appeals for the District of Columbia Circuit vacated the district court decision denying Humana's claims in the case of eight of the twelve hospitals asserting stock acquisition cost claims. *See* App., 14a-22a. Humana does not seek review of that portion of the District of Columbia Circuit's decision.

B. Statutory Framework.

1. This case calls for an interpretation of two sections of the Medicare Act. The first provision, 42 U.S.C. § 1395x(v)(1)(A), which was part of the Medicare Act as originally enacted in 1965, requires the Secretary to reimburse hospitals for their "direct and indirect costs" of furnishing hospital services. Humana claims that its capital costs are indirect costs of patient care, and that reimbursement for its capital costs must comply with the requirements of this section.

Endorsement of Humana's interpretation of the statute has two implications. First, Humana would be entitled to reimbursement for its *actual* cost of obtaining equity capital, which the District of Columbia Circuit recognized as an "indirect cost" of patient care. Second, Humana would be entitled to an individualized determination of its actual costs of equity capital and, if the methods adopted by the Secretary in regulations to calculate payments to Humana produced reimbursement that is inadequate, the Secretary would be required to make "suitable retroactive corrective adjustments" for each fiscal year at issue. *See* 42 U.S.C. § 1395x(v)(1)(A)(i).

2. The Court of Appeals, however, sustained the Secretary's contention that proprietary costs are not indirect costs of patient care.[8] This finding directly contradicts the Secretary's own regulations, which during all relevant periods specified that:

> . . . a reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers.[9]

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[8] *See* App., 8a-9a (stock maintenance costs); *id.* 9a-12a (income taxes); *id.* 12a-14a (return on equity capital).

[9] *E.g.*, 20 C.F.R. § 405.429 (1976). The regulations regarding a return on equity capital were amended in 1983 to reflect the implementation by Congress of a new reimbursement program which included changes in reimbursement levels for capital costs of proprietary hospitals. 48 Fed. Reg. 39811 (Sept. 1, 1983), *codified at* 42 C.F.R. § 405.429 (1984).

Similarly, as noted above, this finding is directly contrary to the *Humana* court's stated understanding that "Indirect costs include such items as return on equity capital. . . ." App., 3a.

3. In reaching this conclusion, the Court agreed with the Secretary's contention that Humana's hospitals could claim a return on equity only as prescribed by a different section of the Medicare Act that has absolutely nothing to do with investor-owned hospitals.[10] This provision of the Medicare Act, which is the second section of the Act that must be evaluated in this case, was adopted in 1966 to require the Secretary to guarantee nursing homes a formula-derived rate of return on equity capital. *See* 42 U.S.C. § 1395x(v)(1)(B).[11]

4. Upon concluding that the claims of Humana's hospitals had to be evaluated under the 1966 nursing home amendment, the court of appeals rejected Humana's contention that it was entitled to the protections of § 1395x(v)(1)(A). First, the court reasoned that Humana was not entitled to reimbursement for its actual costs of attracting and maintaining equity capital, but instead was limited to the far lower rate of return on equity capital established under the 1966 nursing home amendment. App., 13a. Second, the court rejected Humana's claim that it was entitled to an individualized determination of its actual amount of proprietary costs it incurred, because the right to that adjudication does not exist for disputes over reimbursement levels for payments under the 1966 nursing home amendment, but instead extends only to disputes over reimbursement levels for "costs." App., 14a.

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[10] *See* App., 14a.

[11] *See infra* at 16-17.

REASONS FOR GRANTING THE WRIT

I. THE DECISION BELOW IGNORES ESTABLISHED PRINCIPLES WHICH HAVE HISTORICALLY RECOGNIZED THE ACTUAL COSTS OF CAPITAL AS A COST OF GOODS AND SERVICES

In producing goods or supplying services, the expenses incurred by an investor-owned corporation associated with its proprietary status and the attraction of private investment capital historically have been recognized as "costs" for which the corporation must be reimbursed. This established principle is best reflected in this Court's decision in *Federal Power Commission v. Natural Gas Co.*, 315 U.S. 575 (1942). There, in defining the statutory term "lowest reasonable rates" under the Natural Gas Act, *see* 15 U.S.C. § 717, this Court concluded that the "Congressional standard coincides with that of the Constitution." 315 U.S. at 586.

Indeed, any other construction would have been nonsensical: Congress knew that it could not induce the voluntary sale of adequate supplies of natural gas by prescribing statutory payments that by definition were confiscatory. Similarly, Congress could not have expected the participation of investor-owned hospitals in Medicare without compensating them for the costs of capital.

The just compensation principles, which have been developed by this Court in nearly a century of ratemaking litigation under a variety of regulatory schemes, clearly established the right to compensation for the costs of capital. For example, this Court has held that "what the company is entitled to ask is a fair return upon the value of that which it employs for the public convenience." *Smyth v. Ames*, 169 U.S. 467, 547 (1898). "Rates which are not sufficient to yield a reasonable return on the value of the property used at the time it is being used to render the services are unjust, unreasonable and confiscatory . . . ." *Bluefield Waterworks & Improvement Co. v. Public Service Commission*, 262 U.S. 679, 690 (1922). The decision of the Court below, by ignoring precedent, is directly contrary to the historical concept of "costs."

The concept of costs under precedent includes compensation for taxes attributable to return on equity, contrary to the decision of the court of appeals. *See* App., 9a-11a. "Normally included as a cost of service is a proper allowance for taxes, including federal income taxes." *FPC v. United Gas Pipeline Co.*, 386 U.S. 237, 243 (1967). Taxes are "properly treated by the company as part of its operating expenses, to be paid out of its earnings before the net amount could be arrived at applicable to dividends, and, if such latter sums were not sufficient to permit the proper return on the property used by the company for the public, then the rate would be inadequate." *Willcox v. Consolidated Gas Co.*, 212 U.S. 19, 51-52 (1908).[12] The income taxes generated by the need of an investor-owned corporation to compensate shareholders for the use of their capital have always been treated as a "cost" of furnishing services under ratemaking programs.

The rejection of this precedent by the Court below on the ground that Medicare participation is voluntary (App., 10a-11a), is without merit. The position of producers under the Natural Gas Act and of hospitals under the Medicare Act is indistinguishable. Unlike public utilities, neither gas producers nor hospitals are required to sell their product or services, the hallmark of a "taking" under the Fifth Amendment. Yet no court has explained why compensation levels for voluntary sales under the Medicare Act need not, under the statute, similarly comply with constitutional standards.[13]

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[12] Contrary to the lower court's decision, the total exclusion of tax liabilities from reimbursement calculations is not warranted because of the disparate tax treatment of different proprietary facilities. *See* App., 10a-11a. Ratemaking agencies have routinely "normalized" a regulated company's year-to-year tax liability "less future consumers be compelled to subsidize present consumers being served by operations accruing tax liabilities." *Chicago v. FPC*, 385 F.2d 629, 633 (D.C. Cir. 1967), *cert. denied*, 390 U.S. 945 (1968).

[13] That Medicare reimbursement is retrospective rather than prospective (App., 11a), does not justify the result below. At most, a retrospective compensation structure might provide greater security of investment, and thereby warrant a lower rate of return than that paid under a prospective rate structure. It does not, however, justify the wholesale exclusion of capital costs from compensation calculations.

II. THE DECISION BELOW IGNORES THE CONGRESSIONAL MANDATE THAT INVESTOR-OWNED HOSPITALS BE REIMBURSED FOR THEIR DIRECT AND INDIRECT COSTS OF PATIENT CARE.

A. Congress Intended That Proprietary Costs Be Reimbursed As "Direct and Indirect" Costs Under Medicare.

Before the inviolate principles underlying the relationship between the government and private enterprise are abandoned in implementing the Medicare Act, the courts must look to the legislative history of that Act to determine if Congress had that intent. "We cannot impute to Congress such a radical departure from established law in the absence of express Congressional command." *Feres v. United States*, 340 U.S. 135, 146 (1950). When the legislative history of the Medicare Act is consulted, it is immediately apparent that Congress explicitly intended to follow universal practice.

The 1965 cost estimates prepared by the Secretary and relied upon by Congress in enacting the "reasonable cost" standard included provisions for the payment of the costs of equity capital of investor-owned hospitals.[14] Moreover, the Senate Finance Committee understood that the reasonable cost standard by necessity had to include reimbursement for capital costs if Medicare was to have any chance of success:

> Without expectation of a "return on capital" there would be little incentive for the development and participation of proprietary institutions necessary to the successful provision of services to beneficiaries of this program. This point appears so obvious to the staff—and to the chief actuary of the Social Security Administration—that had Congress intended to deny

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[14] *Reimbursement Guidelines for Medicare*, Hearings Before the Senate Committee on Finance, 89th Cong. 2d. Sess. at 58, 110, (May 25, 1966) (testimony of Robert G. Meyers, Chief Actuary, Social Security Administration).

> a "cost of capital" factor to proprietary institutions, it would have specifically exproprietary such an expense.[15]

The only reason that the cost of equity capital is even a topic of discussion under Medicare is that a majority of acute care hospitals in this country are government, charitable, or otherwise non-profit facilities, whose capital needs are met by government funding or charitable contributions, and who therefore do not have to compensate investors for the use of capital. Congress understood and accommodated these differences. The Senate Finance Committee observed that:

> Section 1861(v)(1) of Public Law 89-87 [42 U.S.C. § 1395x(v)(1)(A)], which defines 'reasonable cost,' provides for differentiation in reimbursement between proprietary and non-profit institutions. That provision includes the following sentence:
>
> 'The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies and services . . . .'
>
> The key words here are 'various types or classes of institutions.' *Proprietary and non-profit facilities are different types of institutions within the meaning of the statute.*[16]

Senator Russell Long, Chairman of the Senate Finance Committee, was more succinct:

> [I]t was intended that there should be a return on investment to proprietary institutions . . . .
>
> * * *
>
> [I]t is just unbelievable to think that anyone would propose to use proprietary institutions without allowing a return on equity capital . . . .

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[15] *Id.* at 34 (Senate Finance Committee Staff Report).

[16] *Id.* at 29.

> It seems inconceivable to me—to anyone who believes in the free enterprise system—that if you have one fellow competing with someone else, who paid not a nickel for his plant and equipment, had it all given to him by the Government, or had it donated, where the people even made money by donating it we would suggest that they not allow him something on that.[17]

With this background, the Senate Finance Committee reached a very simple conclusion:

> The difference between proprietary and non-profit facilities can be summarized as follows:
>
> (a) tax treatment;
> (b) availability of grants-in-aid and charitable contributions; and
> (c) normal or traditional expectations of reimbursement.
>
> All of these factors persuade the staff that a distinction is called for by the statute.
>
> * * *
>
> . . . . [R]eimbursement to proprietary institutions should be based . . . on a fair return for equity invested in the facility.[18]

In summary, the legislative history of the Medicare Act displays a clear legislative intent that the uniform practice of compensating owners for the use of their capital would be continued.

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[17] *Id.* at 43, 58.
[18] *Id.* at 30.

B. The 1966 Amendment Establishing A Formula For Determining A Return On Equity To Nursing Homes Is Irrelevant To Humana's Claims.

An evaluation of the decision of the court of appeals rests on its invocation of 42 U.S.C. § 1395x(v)(1)(B), which was enacted in 1966 to establish a formula-derived rate of return to be paid to nursing homes.[19] The 1966 nursing home amendment was passed by Congress in reaction to the regulations adopted by the Secretary earlier in 1966 which had denied any reimbursement to investor-owned companies for their cost of capital. *See* 31 Fed. Reg. 7864 (June 1, 1966). These regulations did not comply with congressional intent underlying the 1965 Act: In introducing the 1966 nursing home amendment, Senator Long advised his colleagues that by omitting reimbursement for costs of capital, "They have made a mistake." 112 Cong. Rec. 23644 (Sept. 22, 1966). In this light, the 1966 nursing home amendment must be viewed as mandate to the Secretary to promulgate regulations consistent with original congressional intent.

Both the court of appeals and Secretary, nevertheless, insist that the inadequate return on equity to hospitals is subject to the limitations of the 1966 nursing home amendment. App., 13a-14a. As a result, the court of appeals held that Humana is not entitled to reimbursement for its actual costs of equity capital, but instead is entitled to no more than the amount paid under the formula established for nursing homes under the 1966 amendment. *Id.* 14a. Additionally, the court reasoned that because reimbursement for the cost of capital is a legislative exception to the cost-based standard, Humana cannot invoke the provision of § 1395x(v)(1)(A)(ii) for an individualized determination of its actual costs of equity. App., 14a.

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[19] Pub. L. No. 89-713, § 7, 80 Stat. 1111 (Nov. 1, 1966), *codified at* 42 U.S.C. § 1395x(v)(1)(B).

In reaching the conclusion sought by the Secretary, the court of appeals has misinterpreted the provisions of the 1966 nursing home amendment. The court recognizes that "the plain language of § 1395x(v)(1)(B) must be our guide." App., 23a-24a. The court, nevertheless, concludes that the "plain language" of a statute that on its face refers only to nursing homes is directly applicable to hospitals. *Id.* 13a-14a. In reaching this conclusion, the court of appeals has abandoned this Court's precedent and has ignored the clear intent of Congress, which warrants issuance of a writ of certiorari.

CONCLUSION

For these reasons, petitioners respectfully request that a Writ of Certiorari be issued to review the judgment and opinion of the court of appeals.

Respectfully submitted,

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